MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041328
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10653

DO NOT WRITE ON THIS STUB — AMENDED

VS 300
Rev. 4/59

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED
1			
2	81508	81508	X
3			
4	1		
5	1		
6			
7	1		
8	2		
9			
10			
11	815		
12	52-0		
13			

BY AFFIDAVIT OF

DOCUMENT

FILED NOV 7 1963

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MISSOURI
Length of stay in 1b: 7 Days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARNES HOSPITAL
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Kansas
b. COUNTY
c. CITY OR TOWN: Coffeyville
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 2701 West 1st.St
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First ARLENE Middle D. Last CRAWFORD

4. DATE OF DEATH: Month 10 Day 25 Year 63

5. SEX: Female

6. COLOR OR RACE: White

7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]

8. DATE OF BIRTH: 5/16/1914

9. AGE (last birthday): 49
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (City and state or country): Riverdale, Nebraska

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Arthur Williams

13b. MOTHER'S MAIDEN NAME: Lena Flake

14. NAME OF HUSBAND OR WIFE: Dale O. Crawford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of servi): None

16. SOCIAL SECURITY NO.:

17. INFORMANT: Coffeyville, Kansas
Mr Dale O. Crawford 2701 West 1st.St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aplastic Anemia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Benzene Hexachloride Bone Marrow Intoxication
DUE TO (c): 882-0-15
INTERVAL BETWEEN ONSET AND DEATH: 7 months / 7 months

Nelson L. Taylor M.D. .63 Coroner 10'30

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.
[ ] Yes [X] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [X] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
Inhaled fumes of insecticide (Bug Master)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
in her home on several occasions, latest in August, 1963.

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

20f. CITY, TOWN, OR LOCATION: Coffeyville COUNTY: 10-25-63 STATE: Kansas

21. I attended the deceased from 10-19-63 to 10-25-63 and last saw her/him alive on 10-25-63
Death occurred at 11:10 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): M.D.

22b. ADDRESS: BARNES HOSPITAL

22c. DATE SIGNED: 10-26-63

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal (Auto)

23b. DATE: 10/26/63

23c. NAME OF CEMETERY OR CREMATORY: Restlawn Cemetery

23d. LOCATION (City, town, or county) (State): Coffeyville, Kansas

24. FUNERAL DIRECTOR ADDRESS: Ford Funeral Home Coffeyville, Kansas

25. DATE RECD. BY LOCAL REG.: OCT 28 1963

26. REGISTRAR'S SIGNATURE: Hoard Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed J. Allen Davis Jr.

Licensed Embalmer No. 4053

P. O. Address St. L

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.